12/05/07 Margaret Liza per DR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	C 11/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of five complaint investigations conducted in your facility on 10/22/07 and 11/13/07. The following complaints were investigated: Complaint #NV00016093 was a facility reported incident that a resident was touched inappropriately by another resident. The incident was substantiated with no deficiencies cited. Complaint #NV00016062 was a facility reported incident that a nurse failed to medicate a resident for pain in a timely fashion. The complaint was substantiated with deficiencies cited (F223) (F225). Complaint #NV00016103 was a facility reported incident that a resident was physically restrained and forcibly given medication. The incident was substantiated with no deficiencies cited. Complaint #NV00016048 was a facility reported incident that a resident was entering other resident rooms and moving their belongings and was observed exhibiting inappropriate behaviors in view of other residents. The complaint was substantiated with no deficiencies cited. Complaint #NV00016210 alleged that the facility failed to provide necessary care for two residents. The complaint was unsubstantiated. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	F 000	*This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Hearthstone of Northern Nevada agrees with the allegations and citations listed on the statement of deficiencies. Hearthstone of Northern Nevada maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Hearthstone of Northern Nevada written credible allegation of compliance.* *By submitting this plan of correction, Hearthstone of Northern Nevada does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Hearthstone of Northern Nevada reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.* RECEIVED NOV 29 2007 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debra M. Tota RN	DON	11/28/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223 SS=D	483.13(b), 483.13(b)(1)(i) ABUSE The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that a staff member with a history of abusive behaviors did not continue to abuse residents. Finding include: Resident #1: Resident #1 was admitted to the facility on 3/26/07 with diagnoses including a tibial fracture, osteoporosis, paralysis agitans, depressive disorder, osteoarthrosis, hypothyroidism, and hypertension. The resident was on Hospice for functional decline, and chronic pain. Review of the medical record revealed that on 10/7/07 Resident #1's family had filed a grievance with the facility alleging that Nurse #1 had failed to administer pain medication for 40 minutes after Nurse #1 was made aware of Resident #1's need for pain medication. It further revealed that Nurse #1 was verbally abusive to Resident #1 and her family at the time of the medication administration. Family members were interviewed on 11/8/07 at 10:15 AM. They reported that the nurse had	F 223	F223 Abuse The facility will ensure that a staff member with a history of abusive behaviors does not continue to abuse residents. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: • Residents #1 # 5, have had their grievances addressed to their satisfaction. • Nurse #1 has been terminated. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: • Grievances will be audited on a random basis to assure follow up and resolution. • Random interviews of the residents to assess professionalism and services of the staff. • Social Services to interview residents for satisfaction of care on a random basis weekly x 4 weeks then monthly x 2 months. 11/30/07 Guardian Angels with their resident	

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F 223	Continued From page 2 failed to medicate Resident #1 for 40 minutes after a verbal request for pain medication had been made. They further reported that Nurse #1 had been rude and verbally abusive to the resident on previous occasions, but they were "afraid to report her for fear of retribution." Review of the Nurse #1's employee file revealed that she had been disciplined for additional allegations of neglect and verbal abuse as follows: 10/16/06: Resident #5's family complained that Nurse #1 "is rude and uncaring," and the resident "is afraid to say anything because she feels that" Nurse #1 "will retaliate against her." 10/16/06: Resident #9's "son feels that" Nurse #1 "doesn't get out of her chair to attend to concerns that are pointed out to her." 3/2/07: Nurse #1 allegedly "denied the resident her pain medications." (Resident #5) 3/2/07: Nurse #1 allegedly gave a medication "only once during shift." (Resident #6) 7/2/07: Nurse #1 "had gone and got the resident out of the room and then was standing over her wheel chair yelling at her that Nurse #1 was going to call the police and they would arrest her." "She was very threatening and loud." "The resident" that reported the incident "asked that we did not use her name because she was afraid that Nurse #1 would become upset and treat her differently." (Resident #7) 10/12/07: A hospice nurse filed a complaint against Nurse #1 that the hospice nurse had "felt	F 223	**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:** • Re-education of all staff regarding the Abuse policy and Procedure. • Random resident satisfaction surveys. • Social Service to interview all residents due for Quality of Care prior to the monthly meeting for complaints of failure to respond to Grievances. • Grievances to be addressed at QOC meeting monthly. **How will the facility monitor its corrective action yo ensure that the deficient practice is being corrected and will not recur:** • Results of audits of grievances will be tracked and trended for review at monthly Performance improvement Committee meeting. • Grievances will be reviwed during Quality of Care Meeting monthly for intervention and resolution.	

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F 223	Continued From page 3 a lot of resistance from" Nurse #1. Nurse #1 "was not willing to give a resident pain medications and was not willing to assist" the hospice nurse "in getting the resident settled into bed." The hospice nurse wrote that nurse #1 "stated that the resident must stay up, and not go to bed." Review of the complaint revealed that the hospice nurse had written that Nurse #1 "was off of the hallway for long periods of time." Nurse #2 was interviewed on 11/9/07 at 8:20 AM. She reported that she had failed to take action against Nurse #1 because she "is having difficulty adjusting to to this culture" and that Nurse #1 "does not mean to upset the residents and families, they just do not understand her culture." She further reported that she had failed to investigate or report many of the allegations against Nurse #1.	F 223	Monitored by: Director of Nursing and Director of Social Service Completion date: December 5, 2007	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and	F 225		

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F 225	Continued From page 4 to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to report incidents of alleged abuse to the Bureau of Licensure and Certification. Findings include: The facility's Policy and Procedure labeled "Abuse, Neglect, and Misappropriation of Property" was reviewed and revealed at Identification Tab 5: "All alleged violations concerning abuse, neglect, or misappropriation of property are reported immediately to the Administrator/designee and other enforcement agencies, according to state law including State Survey and Certification Agency (nurse aide registries or licensing authorities)."	F 225	F225 Staff Treatment of Residents The facility will ensure that incidents of alleged abuse are reported to the Bureau of Licensure and Certification. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: • Residents #1 # 5, have had their grievances addressed to their satisfaction. • Nurse #1 has been terminated. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: • Grievances will be audited on a random basis to assure follow up and resolution. • Random interviews of the residents to assess professionalism and services of the staff. • Social Services to interview residents for satisfaction of care on a random basis weekly x 4 weeks then monthly x 2 months.	

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F 225	Continued From page 5 Review of the Nurse #1's employee file revealed that she had been disciplined for additional allegations of neglect and verbal abuse as follows: 10/16/06: Resident #5's family complained that Nurse #1 "is rude and uncaring," and the resident "is afraid to say anything because she feels that" Nurse #1 "will retaliate against her." 10/16/06: Resident #9's "son feels that" Nurse #1 "doesn't get out of her chair to attend to concerns that are pointed out to her." 3/2/07: Nurse #1 allegedly "denied the resident her pain medications." (Resident #5) 3/2/07: Nurse #1 allegedly gave a medication "only once during shift." (Resident #6) 7/2/07: Nurse #1 "had gone and got the resident out of the room and then was standing over her wheel chair yelling at her that Nurse #1 was going to call the police and they would arrest her." "She was very threatening and loud." "The resident" that reported the incident "asked that we did not use her name because she was afraid that Nurse #1 would become upset and treat her differently." (Resident #7) 10/12/07: A hospice nurse filed a complaint against Nurse #1 that the hospice nurse had "felt a lot of resistance from" Nurse #1. Nurse #1 "was not willing to give a resident pain medications and was not willing to assist" the hospice nurse "in getting the resident settled into bed." The hospice nurse wrote that nurse #1 "stated that the resident must stay up, and not go to bed." Review of the complaint revealed that	F 225	What measure will be put into place or what systemic changes will you make to ensure the deficient practice does not recur: • Reeducation of the staff regarding the Abuse policy and Procedure. • Random resident satisfaction surveys. • Social Service to interview all residents due for Quality of Care prior to the monthly meeting for complaints of failure to respond to Grievances. • Grievances to be addressed at QOC meeting monthly. : How will the facility monitor its corrective action to ensure that the deficient practice is being corrected and will not recur. • The facility will review the results of all audits for tracking and trending at the monthly Performance Improvement Meeting.	

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F 225	Continued From page 6 the hospice nurse had written that Nurse #1 "was off of the hallway for long periods of time." Nurse #2 was interviewed on 11/9/07 at 8:20 AM. She reported that she had failed to investigate or report many of the allegations against Nurse #1 to the Bureau of Licensure and Certification. She reported that she had disciplined the nurse by counseling her verbally. The Interim Administrator was interviewed on 11/13/07 at 9:00 AM. She reported that Nurse #2 had not reported many of the allegations to the Bureau of Licensure and Certification. Cross reference Tag F 223	F 225	• Quality of care meeting will review grievances monthly for intervention and resolution. Monitored By: Director of Nursing and Director of Social Services. Completion date: December 5, 2007	